Office of the Health Insurance Commissioner
Health Insurers: Affordability Reports Guidance – March 27, 2009

A. Purpose

The purposes of Insurer's Affordability Plan are to

- Make public its efforts to identify and address underlying costs of care in RI;
- Hold health plans accountable for the efficacy of those efforts; and
- Increase alignment and focus across payers in these efforts.

B. Background: Public Guidance (from OHIC Regulation 2)

"A health insurer's strategies to enhance the affordability of its products will be evaluated based on the following:

(i) Whether the health insurer offers a spectrum of product choices to meet consumer needs;

(ii) Whether the health insurer offers products that address the underlying cost of health care by creating appropriate incentives for consumers, employers, providers and the insurer itself. Such incentives will drive efficiency in the following areas:[1]

(A) Creating a focus on primary care, prevention and wellness;
(B) Establishing active management procedures for the chronically ill population;
(C) Encouraging use of the least cost, most appropriate settings; and
(D) Promoting use of evidence based, quality care;

(iii) Whether the insurer employs provider payment strategies to enhance cost effective utilization of appropriate services; [2]

(iv) Whether the insurer supports product offerings with simple and cost effective administrative processes for providers and consumers;

(v) Whether the insurer addresses consumer need for cost information through

(A) Increasing the availability of provider cost information; and
(B) Promoting public conversation on trade-offs and cost effects of medical choices."

[1] These four areas are considered OHIC's "Affordability Principles"
[2] Health Plan implementation strategies may include – provider payment reform, provider measurement and feedback, benefit design, consumer education, delivery system change initiative, program management, administrative simplification etc.

C. Current Situation: Projected Trend rates*

Expense Category	Share of Total Medical Expense (%) SG / LG	Price Trend (%) SG/LG	Utilization Trend (%) SG/LG	Overall Trend 2009 to 2010 (%) SG/LG		Prior Year (2008-2009) SG/LG
Inpatient Hospital	23% / 24%	10% / 10%	0.4% / 0.5%	15.5% / 16.3%		11.0% / 9.9%
Outpatient Hospital	31% / 32%	7.8% / 7.8%	0.4% / 0.5%	12.9% / 13.8%		11.0% / 9.9%
Pharmacy	17% / 16%	4.8% / 4.8%	3.1% / 3.1%	11.0% / 11.9%		12.5%/12.5%
Primary care physician.	5% / 5%	3.8% / 3.8%	1.9% / 2%	10.1% / 10.9%		11.0%/9.9%
Other Physician/Other	24% / 23%	3.8% / 3.8%	1.9% / 2%	10.1% / 10.9%		11.0%/9.9%

* These figures should duplicate those in your plan's rate factor filing.

D. System Affordability Strategy

1. List and comment on the three most significant drivers affecting medical costs that you see in the Rhode Island market in the next five years.

a) Increased Acute Care Hospital unit cost pressure.
Based on an expectation that local hospitals will experience increased financial strain as a result of the worsening economic climate (deteriorating investment portfolios, increases in bad debt and/or uncompensated care, decreased government program reimbursements). The expectation is that hospitals will try to offset with increased pricing demands from the commercial payors.

b) Increased intensity of delivered services.
Continued trend toward increased intensity of medical services delivered per insured across the entire continuum of care; disproportionate use of specialty care; expanding use of diagnostic testing; increased intensity of hospital confinements.

c) Risk pool deterioration as a result of the worsening local economic climate. Possibility that economic pressures / accelerating unemployment might drive lower insured enrollment and deteriorate the insured risk pool if healthier lives disproportionately forgo insurance coverage; increased enrollment of heavily subsidized COBRA lives.

2. Briefly (in less than 1 page), what is your company's strategy – given these cost drivers - to improve the overall affordability of health care in RI in the next five years?

UnitedHealthcare is well diversified and supports health care modernization with attention to improving access to quality care while managing rapidly growing health care costs. Success requires a practical and sustainable approach focused on comprehensive change across the full spectrum of health benefit coverage, care delivery systems, and consumer responsibility. We support policies that give employers the financial incentive and flexibility to extend and improve upon prevention, wellness and disease management programs and provide incentives for the appropriate use of resources. This will help to promote the mitigation of behaviors that contribute to chronic conditions and help keep more workers healthy and productive while driving down health care costs for everyone.

We support changing the way the system pays for care, by aligning cost, access, and quality so that it rewards efficiency and quality rather than volume and intensity of services provided. It means giving providers the financial incentives to better coordinate care to provide better quality, preventing catastrophic illness and the accompanying costs - for example, reducing unnecessary hospital readmissions. We believe that improving the delivery system requires encouraging facilities and providers to extend the hours care is available. It also requires increasing access to primary care providers and supporting reimbursements for their services, which are central to delivering better coordinated, higher quality and earlier preventive care for patients. We support improving health IT so information about best practices and the comparative effectiveness of treatments can be shared in a useful and timely manner, reducing errors and ensuring efficient use of medical resources. We support transparency in health care performance so consumers can know where quality health care services are available and the associated costs.

Specifically, UnitedHealthcare strives to do it's part in increasing the overall affordability of health care in Rhode Island in the next five years by focusing on a comprehensive strategy. We have briefly outlined below some of the core strategies UnitedHealthcare will develop and maintain over the next five years:

- A focus on products with the consumer and provider in mind. These products emphasize prevention and wellness, with a focus on quality and efficiency though use of our Premium Designation Program. Some examples of these products include consumer-driven health plans, "Edge", Tiered Benefit Plans, "Simply Engaged", "Pledge Plan", and "Vital Measures Program" as well as programs that drive members to seek care at the appropriate place of service
- Increasing and maintaining a strong focus on consumer engagement through our personal activation campaigns, administrative simplification, lifestyle programs and member wellness tools such as NurseLine, Personal Health Record and focused coaching through personal health support
- Ensuring our members have the tools they need to make informed decisions about their healthcare through programs which support transparency, quality and efficiency such as the Premium Designation Program.
- Encouraging quality at the end of life through care options and education around hospice and other alternatives
- Sharpening our focus on administrative simplification by driving health information technology adoption and interconnectivity and exploring new technology initiatives.
- Endeavor to both decrease the variability in care and ensure that our members are receiving care based on upon acceptable evidence-based medicine guidelines in all settings by increasing our focus on the inpatient setting through our care coordination clinical model supported, by the deployment of onsite nurses for various disease conditions, promoting the

appropriate level of care, and proactive engagement to collaborate on discharge planning and readmit prevention.

- Develop and maintain our focus on wellness through the implementation and refinement of programs focused on cardiovascular disease prevention, reducing unnecessary fusion surgeries through our Treatment Decision Support Program, expanding access to primary care, total population management, appropriately managing advanced imaging services, integrated behavioral health programs focused on improving screening of depression, anxiety and substance abuse, and follow-up care after inpatient confinement.
- Continue to invest in health information technology

3. What is your resulting anticipated overall annual trend for the next three years:

   a) Baseline trend: Assuming consistent membership + benefit mix, with no new programs.

   CY 2010 13.5%
   CY 2011 13.0%
   CY 2012 13.0%

   b) Baseline trend: After adjusting for membership/benefit mix

   CY 2010 9.4%
   CY 2011 9.2%
   CY 2012 9.8%

   c) Adjusted Trend: Adjusted for impact of affordability strategy outlined in your response to question number two.

   CY 2010 7.4%
   CY 2011 7.2%
   CY 2012 7.7%

E. Rate Factor Standards for Medical Cost Improvement

Specific Health Plan Affordability Priorities and Standards have been developed by OHIC with the guidance of the Health Insurance Advisory Council for commercial insurers doing business in Rhode Island.

To show adherence with their statutory obligation to engage in "policies that advance the welfare of the public through overall efficiency, improved health care quality and appropriate access", in conjunction with their annual filing of rate factors for small and large group commercial insurance products, health insurers must demonstrate that they meet standards for each of the four specific system affordability priorities listed below (the details of which are provided in an attachment to this guidance, excerpted from the document: "System Affordability Priorities and Standards for Health Insurers in Rhode Island" available on the OHIC website.)

System Affordability Priorities:[3]

Health plans will improve the affordability of health care in Rhode Island by focusing their efforts upon provider payment reform, beginning with primary care. Achievement of this goal will not add to overall medical spend in the short-term, and is expected to produce savings thereafter. Specific areas of focus in support of this goal are as follows:

I. Expand and improve the primary care infrastructure in the state- with limitations on ability to pass on in premiums)
II. Spread Adoption of the Chronic Care Model-Style Medical Home
III. Standardize EMR incentives
IV. Work toward comprehensive payment reform across the delivery system

1. Please confirm that you have read and understand the priorities and standards, and your specific obligations as described in "System Affordability Priorities and Standards for Health Insurers in Rhode Island" [4].

2. Please submit to OHIC your initial recommendations for an OHIC oversight process that would address any concerns you might have for meeting the standards. These will be taken under advisement.

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[3] Subject to final modification and approval at the April 21, 2009 Health Insurance Advisory Council Meeting.
[4] Subject to final modification and approval at the April 21, 2009 Health Insurance Advisory Council Meeting.

F. Company Specific System Affordability Initiatives

Please list the five most significant (in term of overall financial impact) initiatives[5] your company is undertaking to improve the affordability of healthcare in Rhode Island in the next three years. [6]

Initiative*	OHIC Affordability Principles targeted	Description	Implementation Strategies employed[7]
1. Expand Coordination of Care through Primary Care	Primary Care PCMH EMR	Building new programs that incentivize and encourage primary care through the use of alternative payment methodologies and administrative simplification.	(1) Ongoing Provider measurement and feedback (2) Program management (3) Benefit design (4) Administrative simplification
2. Inpatient Optimization/ through Milliman Guideline and EBM Application	PCMH Primary Care	Ensuring that inpatient stays are appropriately managed in accordance with Milliman and evidence-based medicine guidelines. Providing onsite clinical staff to assist in coordinating care for our membership. Ensuring the appropriate use of levels of care within the facility setting and support discharge planning.	(1) Evidence-based medicine guideline application (2) Program management, care coordination and application of best practices
3. Inpatient Optimization through Care and Disease Management	PCMH Primary Care	Working jointly with physician and hospital staff to decrease unnecessary admits and readmits, support entry into appropriate transitional care settings and drive referrals to programs that will assist with long term illness and chronic diseases.	(1) Program management (2) Provider measurement and feedback (3) Consumer education

[5] Initiatives are specific programs, projects, sets of actions, priorities etc. Financial impact is based on internal assessment.

[6] Proprietary information: Because the affordability of health care encompasses many stakeholders and improving it involves changing basic elements of how medical care is used, delivered and paid for, these efforts are essentially public or collective in nature. However, as private entities, health plans compete in a market and have proprietary information to maintain a competitive advantage. Affordability Reports should not disclose proprietary information.

- What is proprietary: trade secrets; efforts which increase member, consumer or provider loyalty, unless they impose or shift costs to the public.
- What is public: efforts to improve performance of the delivery system; administrative initiatives; efforts to improve public health; collaborations with other stakeholders.

[7] E.g.: provider payment reform, provider measurement and feedback, benefit design, consumer education and incentives, delivery system change initiatives, program management (e.g. care management, disease management) , administrative simplification etc.

Initiative*	OHIC Affordability Principles targeted	Description	Implementation Strategies employed[7]
4. ER Management	Primary Care	Reducing ER utilization by developing member and physician incentives to drive utilization to the primary care and urgent care settings.	(1) Benefit design (2) Provider measurement and feedback (3) Consumer education
5. Member/Employer Engagement	Primary Care PCMH	Promote employer and member personalized health engagement through wellness and disease and care management programs. Promote the use of the consumer activation index, risk assessments, premium designation program and products such as "Simply Engaged".	(1) Benefit design (2) Consumer education and incentives (3) Program management (4) Provider measurement and feedback

*The aforementioned initiatives will account for approximately 0.5% to 1.5% in expected return.

Appendix A: Detailed Affordability Standards – March 2009

These proposed standards, developed with the guidance of the Health Insurance Advisory Council, would be for commercial insurers doing business in Rhode Island. To show adherence with their statutory obligation to engage in "policies that advance the welfare of the public through overall efficiency, improved health care quality and appropriate access", in conjunction with their annual filing of rate factors for small and large group commercial insurance products, health insurers would have to demonstrate that they meet the following standards.

Standard #1: Primary Care Spend

1. March 2009: The insurer shall commit in writing that the rates that the insurer will propose to charge to small and large employers in Rhode Island for 2010 shall demonstrate that the proportion of the insurer's medical expense to be allocated to primary care for the 12 months starting January 1, 2010 shall be one percentage point higher (e.g., from 5% to 6% of medical expense) than reflected in actual spending for the twelve months starting January 1, 2008.

This proportion shall continue to increase by one percentage point per year, for five years.

a) Tufts Health Plan, as a new entrant, shall be required to achieve a 6.9% primary care spend (one percentage point higher than the current market average), by January 1, 2010.
b) Resulting primary care expense allocation shall be reported every six months, starting in February, 2009, in accordance with the definition provided by OHIC.

2. September 2009: The insurer must submit a plan to OHIC that demonstrates how the increase is to be achieved, and that it will be accomplished in a manner that does not contribute to the increase of premiums. That is, the insurer may fund the increase by:
    a. increasing primary care payments, while either decreasing payments, not increasing payments, or funding smaller increases than what the insurer has historically awarded to other service providers, and/or
    b. increasing volume of primary care delivery and decreasing volume of non-primary care services.

3. March 2010: Rate factors that the insurer proposes to use for rates to charge to small and large employers in Rhode Island for the 12 months beginning July 1, 2010 shall reflect the new allocation of payments to primary care beginning Jan 1, 2010 and an additional one point higher allocation of payments to primary care beginning Jan 1, 2011 as compared to actual spending for the twelve months starting January 1, 2008.

4. March 2011:
    a. The insurer must demonstrate whether the required increase in primary care expenses projected for the 12-month period starting Jan 1, 2010 was achieved, and if so, exactly how it

was accomplished in a manner that did not contribute to a larger increase in medical expense than would have otherwise occurred.

b. Rates factors that the insurer proposes to use for rates to charge to small and large employers in RI for the twelve months starting July 1, 2011 shall demonstrate that the proportion of medical expense to be allocated to primary care shall be an additional one percentage point higher for the twelve months starting January 1, 2012 than reflected in actual spending for the twelve months starting January 1, 2011.

5. OHIC may, at its discretion, require a review of the insurer's calculations by an independent auditor.

Standard #2: Chronic Care Model-style Medical Home

1. March 2009: The insurer shall commit in writing to supporting an expansion of the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) during the period July 2009 through June 2010.
    a. The expansion shall entail an increase of at least 15 PCP FTEs[8] from the current 28 FTE level, including the addition of new practices beyond the initial 5 CSI-RI practice participants.
    b. The expansion shall include the Chronic Care Model-based elements that were included in the initial CSI-RI implementation, including training in the Chronic Care Model, and funding of a nurse case manager, among other CSI-RI elements.

2. March 2010:
    a. The insurer must demonstrate that the successful expansion of CSI-RI to at least 15 new physician FTEs from new practices occurred during the 12 month period starting July 2009
    b. The insurer shall commit in writing to supporting an additional expansion of the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) during the period July 2010 through June 2011, adhering to the same parameters as for the 2009-2010 expansion.

Standard #3: Mandated EMR Incentive

1. March 2009: The insurer shall commit in writing to the implementation of a physician (primary care and/or specialty care) EMR adoption incentive on or before January 2010, that meets the following standards:

[8] The addition of 15 physician FTEs will increase the patients affected by the program, as a percentage of the total state population from 2.38%, to 3.69%, the latter being the national multi-payer medical home benchmark level that PA will achieve in 2009.

a. The incentive must be applied only to practice adoption of EMRs with:

   i. certification by the Commission for Healthcare Information Technology (CCHIT℠)[9], and

   ii. registry functionality to promote patient tracking in the manner prescribed by NCQA PPC-PCMH standards for a medical home.

b. The incentive must be equivalent in value to one or more of the following thresholds[10]:

   i. initial payment per physician to subsidize the cost of EMR acquisition, adjusted for carrier market share as follows[11]; and,

      1. BC: $5,000 or more, up to practice maximum of $15,000
      2. United: $2,500 or more, up to practice maximum of $7,500
      3. TuftsHP: $750 or more, up to a practice maximum of $2,250

   ii. support for the cost of EMR implementation and operation in the form of pay-for-participation payments equal to $.60 PMPM or in increased fees, totaling in value at least 3% greater than the insurer's standard fee schedule.

2. March 2010: The insurer shall demonstrate the implementation of a physician (primary care and/or specialty care) EMR adoption incentive that meets the standards defined above. As part of its rate factor filing the insurer should submit data on the payments made as part of the incentive program.

Standard #4: Fundamental Payment Reform

1. March 2009: The insurer shall commit in writing to participate in a state-facilitated process to explore, assess, recommend and adopt reforms to health care service payment in Rhode Island. Participation shall include:
   a. active engagement as a member of the stakeholder body to be convened by OHIC in coordination with other state governmental entities, and
   b. provision of non-competitive information to the body to assist it in its deliberations.

2. Should the body have convened during 2009, the insurer must have demonstrated participation consistent with the requirements of #1 above.

3. March, 2010: To be decided

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[9] CCHIT certification standards for Ambulatory Electronic Health Records can be accessed at www.cchit.org/certify/ambulatory/index.asp.

[10] These standards are informed by national analysis and practices by payers in Rhode Island and elsewhere in the U.S.

[11] Based on per physician EMR adoption cost of $33,000, a target of 25% overall subsidy, and market shares of 60/30/10 respectively.